DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 03-009

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/03

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 ($3,800K)
b. FFY 2004 ($16,000K)

8. CURRENT PAGES:
i, ii, iii, iv, 1, 3, 5, 6, 6.1 to 6.2, 7, 8, 11, 15, 20, 33.2, 33.3, 33.4, 34, 36, 43, 43.3, 43.4, 43.5, 46, 48, 50, 51, 52 .....
6.3 to 6.5, 7.2, 7.4, 7.5, 10.1, 14.1, 26.1.a., 26.1.b., 26.1.c., 43.1.b, 43.2.b, 62, 63, 64 .....
7.3 .....
43.1.a. .....
43.2.a. .....

9. NEW PAGES:
Same

None
7.1
43.1
43.2

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Rates

11. GOVERNOR'S REVIEW *(Check One)*:
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☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Peggy B. Handrich for

13. TYPED NAME:
Mark B. Moody

14. TITLE:
Administrator, Division of Health Care Financing

15. DATE SUBMITTED:
September 25, 2003

16. RETURN TO:
Mark B. Moody
Administrator, Division of Health Care Financing
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
SEP 29 2003

18. DATE APPROVED:
APR 29 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
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20. SIGNATURE OF REGIONAL OFFICIAL:
Brian for Smith

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

RECEIVED
SEP 29 2003
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FORM HCFA-179 (07-92)

# Wisconsin Medicaid Program
# Inpatient Hospital State Plan
## Method and Standards For Determining Payment Rates
## With Amendments Effective July 1, 2003

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TN # 03-009
Supersedes
TN # 01-005

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*Approval Date* _____

Effective Date 07/01/03

# Wisconsin Medicaid Program
# Inpatient Hospital State Plan
# Method and Standards For Determining Payment Rates

## SECTION 1000
## OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT

This section is a brief overview of how reimbursement to hospitals is determined for inpatient services that are provided by hospitals to eligible recipients of the Wisconsin Medicaid Program (WMP). The WMP uses a reimbursement system which is based on Diagnosis Related Groupings (DRGs). The DRG system covers acute care hospitals and hospital institutions for mental disease (IMDs). Excluded from the DRG system are rehabilitation hospitals, State IMDs and State veterans hospitals which are reimbursed at rates per diem. Also, reimbursement for certain specialized services are exempted from the DRG system. These include acquired immunodeficiency syndrome (AIDS), ventilator-assisted patients, unusual cases and brain injury cases. Special provisions for payment of each of these DRG exempted services are included in the plan. As of July 1, 1995, organ transplants are covered by the DRG system.

The WMP DRG reimbursement system uses the grouper that has been developed for and used by Medicare, with enhancements for certain perinatal, newborn and psychiatric cases. The grouper is a computer software system that classifies a patient's hospital stay into an established diagnosis related group (DRG) based on the diagnosis of and procedures provided the patient. The WMP applies the Medicare grouper and its enhancements to Wisconsin-specific claims data to establish a relative weight for each of over 550 DRGs based on statewide average hospital costs. These weights are intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with a DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with a weight of 1.0, while a hospital stay assigned a DRG with a weight of .5 would require half the resources.

Each hospital is assigned a unique "hospital-specific DRG base rate". This hospital-specific DRG base rate includes an adjustment for differences in wage levels between rural and metropolitan areas throughout the state. This rate also includes an amount, based on the hospital's historical costs, for capital cost and for direct costs of medical education programs. For some hospitals, the rate also includes additional amounts for a serving a disproportionate share of low-income persons or for the hospital being located in a rural area.

Given a hospital's specific DRG rate and the weight for the DRG into which a stay is classified by the grouper, payment to the hospital for the stay is determined in multiplying the hospital's rate by the DRG weight.

A "cost outlier" payment is made when the cost of providing a service exceeds a pre-determined "trimpoint". Each inpatient hospital claim is tested to determine whether the claim qualifies for a cost outlier payment. A length-of-stay outlier payment is available upon a hospital's request for children under six years of age in disproportionate share hospitals and for children under age one in all hospitals.

For additional information, contact:

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*DRG.* DRG means Diagnosis Related Groups which is a patient classification system that reflects clinically similar groupings of services that can be expected to consume similar amounts of hospital resources.

*Hospital-Specific DRG Base Rate.* The payment rate per discharge which will be calculated for and assigned to each hospital by the Department for the rate year. This is the rate by which a DRG weight is multiplied to establish the amount of payment for an individual inpatient stay. Some provisions may allow this rate to change during the rate year.

*IMD.* Institution for Mental Disease, as defined in 42 CFR 435.1009. When used in this Plan, IMD means "hospital IMD".

*Long Term Care Hospital.* An acute care hospital reimbursed by Medicare under the Medicare prospective payment system for long-term care hospitals (LTCH).

*Non-Border Status Hospital.* A hospital not located in Wisconsin and which has not been certified by the WMAP as a border status hospital.

*Prospective Rate per Diem.* The hospital-specific rate for each day of service.

*Rate Year.* The twelve month period from July 1 through June 30 during which rates established under the annual rate update are to be effective for most, if not all, hospitals.

*Rehabilitation Hospital.* A hospital that provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures, and multiple trauma to at least 75% of its patient population. IMD hospitals cannot be considered rehabilitation hospitals under the provisions of this plan.

*WMAP.* Wisconsin Medical Assistance Program, also referred to as Medicaid, Medical Assistance (MA) or Title XIX.

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## SECTION 3500
## DIFFERENCES IN RATE SETTING BETWEEN IN-STATE HOSPITALS AND OUT-OF-STATE HOSPITALS

### 3510 Hospitals Located in Wisconsin

General hospitals and most specialty hospitals located in Wisconsin (in-state hospitals) are reimbursed according to the DRG based payment method described in section 5000 herein. All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000. As of July 1, 1995, organ transplants are paid under the DRG based payment method.

Certain specialty hospitals are reimbursed under a rate per diem methodology, not the DRG based payment system. Rehabilitation hospitals as defined in section 3000 are paid a per diem rate according to section 6300. The State's mental health institutes are paid under the payment rates described in section 6200. State operated hospitals which primarily service military veterans are paid under the payment rates described in section 6250.

*Administrative Adjustment of Rates.* In-state hospitals may request an administrative adjustment to their payment rates under the criteria described in section 11000. The due dates for requesting adjustments are described in that section.

*Use of Cost Report In Rate Setting.* An in-state hospital's audited cost report is required for establishing certain components of the hospital's specific payment. The specific components include the disproportionate share adjustment (§5240), the rural hospital adjustment (§5260), outlier payments (§4322), capital cost payments (§5420) and the direct medical education payments (§5520).

# SECTION 5000
# DRG BASED PAYMENT SYSTEM
# FOR IN-STATE HOSPITALS AND MAJOR BORDER STATUS HOSPITALS

## 5010 INTRODUCTION

A hospital is paid a prospectively established amount for each discharge under the DRG based payment system. In the Department's annual rate update, a "hospital-specific DRG base rate" is calculated for each hospital. This rate is the result of adjusting a "standard DRG group rate" for the wage area of each hospital. In addition, if the hospital qualifies, the rate includes disproportionate share (§5240) or rural hospital adjustments (§5260). As of July 1, 1997, the hospital-specific DRG base rate includes payment for capital costs (§5400) and direct medical education costs (§5500). As of July 1, 1999, the indirect and direct medical education costs are not included in out-of-state hospital-specific DRG base rates. As of July 1, 2003, an indirect medical education cost adjustment is not included in any hospital-specific DRG base rate.

For each Medicaid recipient's stay, a hospital's specific DRG base rate is multiplied by the relative weighting factor for the diagnosis related group (DRG) which applies to the hospital stay. The result is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high cost cases which are described in sections 5321 through 5324 or for certain very long lengths of stay which are described in sections 5331 through 5334.

## 5020 HOSPITALS COVERED BY DRG SYSTEM

Most general, specialty and IMD hospital providers in Wisconsin and most major border status hospitals will be paid according to the DRG based payment system described in this section 5000. Minor border status hospitals, out-of-state non-border status hospitals, rehabilitation hospitals, and State operated IMD hospitals and veteran hospitals are not covered by this section 5000.

## 5030 SERVICES COVERED BY DRG PAYMENTS

All covered services provided during an inpatient stay, except professional services described in §5040, shall be considered hospital inpatient services for which payment is provided under this DRG based payment system. (Reference: Wis. Admin. Code, HSS 107.08(3) and (4))

All inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

As of July 1, 1995, organ transplants are covered by the DRG based payment method.

## 5040 PROFESSIONAL SERVICES EXCLUDED FROM DRG PAYMENTS

Certain professional and other services are excluded from the DRG payment system. Professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded, when the professionals are functioning in the capacity of:

| | | |
|---|---|---|
| Physicians | Optometrists | Pharmacy, for take home drugs on the date of discharge |
| Psychiatrists | Hearing aid dealers | |
| Psychologists | Audiologists | Durable medical equipment and supplies for non-hospital use |
| Physician assistants | Podiatrists | |
| Nurse midwives | Independent nurse practitioners | Specialized medical vehicle transportation |
| Chiropractors | Anesthesia assistants | |
| Dentists | Certified registered nurse anesthetists | Air, water and land ambulance |



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## 5100 STANDARDIZED DRG PAYMENT FACTORS

Certain standard factors are used in the determining the amount of payment hospitals receive for services covered by the DRG based payment method. The Department adjusts these standard factors for each rate year, July 1 through June 30. They include the DRG grouper, the DRG weights and the standard DRG group rates.

### 5130 DRG Grouper

The DRG grouper is a patient classification software system which results in a patient stay being classified into one "diagnosis related group" (DRG). The WMP DRG reimbursement system uses the grouper developed for Medicare based on "major diagnostic categories" (MDCs). For newborns, WMP has enhanced the grouper's MDC 15, Newborns and Other Neonates with Conditions Originating in the Perinatal Period. For psychiatric stays, the grouper's MDC 19, Mental Diseases and Disorders, is also enhanced.

Annually, beginning with July 1, 1992, updated versions of the Medicare grouper will be used by the WMP. The Medicare grouper version, which is released by CMS for use by Medicare beginning on October 1 of each calendar year, will be implemented for MA discharges occurring on and after July 1 of the subsequent calendar year. (For example, on October 1, 1991 CMS began to use Version IX of the Medicare grouper. Therefore, for dates of discharge on and after July 1, 1992, the WMP will apply that Version IX grouper.)

### 5140 DRG Weights

DRG weights reflect the relative resource consumption of each inpatient stay. The weights are determined from an analysis of past services provided by hospitals, the claim charges for those services and the relative cost of those services. WMP recipient inpatient hospital claims are used in order that the weights which are developed are relevant to the types and scope of services provided to WMP recipients.

Annually, beginning with July 1, 1992, revised DRG weights will be established based on (1) the updated version of the Medicare grouper, (2) more current claims information and (3) more current inpatient hospital cost report information.

*5140.1 Claims Used.* Claims for a period of at least three years for WMP certified hospital providers in Wisconsin are used. The selected period of claims is not to end more than twenty-four months nor less than nine months prior to the July 1st day on which the revised DRG weights are to be implemented. Claims not covered by WMP's DRG based payment system are not used. These are claims for which payment is made at rates determined under Sections 6000 and 7000. Also not used are claims from any hospital designated a critical access hospital (CAH) during the selected period of claims. This exclusion of claims applies to hospitals newly designated as a CAH or discontinued as a CAH anytime during the selected period of claims.

*5140.2 Cost Report Used.* The WMP uses the cost report for each hospital's most recently completed reporting period for which an audit adjusted cost report is available to the Department as of the February 28th date prior to the July 1st day on which the revised DRG weights are to be implemented except the Department may, at its option, use audited cost reports it receives later. Costs are inflated as described below for the calculation of weights.

*5140.3 Weights Calculated.*

The updated version of the Medicare grouper described in section 5130 above is applied to the historical claims from the period described in subsection 5140.1 above. Each claim is classified to and assigned its appropriate diagnosis related grouping (DRG) by the grouper.

The cost of each inpatient hospital claim is calculated. This is a hospital-specific claim cost that requires correlating the services charged on the claim to related cost centers of the hospital's cost report. For each claim, accommodation charges for the hospital stay are multiplied by the cost-to-charge ratio of accommodation cost centers in the respective hospital's cost report. The result is the cost of accommodations for the hospital stay. Ancillary service charges are multiplied by the cost-to-charge ratio of ancillary cost centers in the respective hospital's cost report providing a cost for ancillary services Acquisition charges for transplanted organs are multiplied by cost-to-charge ratios for the respective organ. The resulting accommodation cost, ancillary service cost and organ acquisition costs of each claim is summed resulting in the total cost of the inpatient stay.

The cost of each inpatient stay is further standardized (or adjusted) for area wage differentials and reduced for the cost attributed to capital costs, direct medical education costs and outlier costs.

Each claim's cost is inflated by an inflation multiplier to the current rate year. The inflation multiplier is derived from indices in the publication, "Health-Care Cost Review", that is published quarterly by Global Insight, Inc.. Specifically used are the total market basket indices from the tables entitled "CMS Hospital Prospective Reimbursement Market Basket."

The average cost of the claims by each DRG is calculated. Also, a combined overall average cost of all DRG claims is calculated. However, excluded from this overall average are claims grouped to MDC 15, Mental Disease and Disorders, for Milwaukee County Mental Health Center. The weight for each respective DRG is the average cost of the respective DRG's claims divided by the combined overall average cost. In this way, weights are established for over 550 DRGs.

Random anomalies and incongruities in the resulting weights are reviewed and analyzed in the light of the prior year weights and the cost and volume of claims involved. The questioned DRG weights are adjusted, if considered appropriate, to a reasonable amount based on the analysis. It should be noted that low-volume DRGs are especially vulnerable for significant year-to-year swings in their weight. A significant decrease in the weight of any individual DRG is limited unless cost, volume and central tendency and deviation data justify the significant decrease. A listing of the resulting proposed and final DRG weights are disseminated to in-state and major border status hospitals.

*5140.4 Cochlear Implants.*

A separate weighting factor is provided for inpatient hospital stays for cochlear implants. Payment is available upon written request by the hospital for payment at this weight and is only available for a claim that covers cochlear implant surgery and the cost of the apparatus. This is a low volume inpatient procedure for Medicaid recipients but is significantly more expensive than the broadly inclusive DRG #49, major head and neck procedures, in which cochlear implants are grouped (assigned). A claim for surgery without the apparatus cost will be covered under DRG #49. The cochlear implant weight was established based on the cost of 17 inpatient stays from February 1991 to August 1993. This set of claims covered some WMP recipients but mostly persons not covered by WMP. When a sufficient number of inpatient claims from a current period of no more than 7 years is available for WMP recipients receiving cochlear implants, a weight will be calculated based on those claims. The method of calculating a weight is that described above for other weights.

**5150 DRG Weights For MDC 15, Mental Diseases and Disorders**

The WMP has expanded the nine standard diagnosis related groupings (DRGs) of MDC 15 for Mental Diseases and Disorders. For each of the DRGs, separate weighting factors are constructed for two age ranges: (1) over age 17 and (2) age 17 and younger. The result is 18 weighting factors. These weighting factors apply to hospital stays for mental diseases and disorders in acute care hospitals and in hospital institutions for mental disease (IMD) except Milwaukee County Mental Health Center.

A separate schedule of 18 DRG weighting factors are constructed for the Milwaukee County Mental Health Center (MCMHC) for hospital stays classified to MDC 15, Mental Diseases and Disorders. Weights are calculated as described in section 5140.3 above using average cost by DRG for hospital stays in the MCMHC that are classified to MDC 15.

As noted in subsection 5140.3, random anomalies and incongruities in the resulting weights are reviewed and adjustments made if considered appropriate.